NOAA Health Services Aviation Questionnaire

Name: _____ **E-Mail: _____**
Last First **Supervisor: _____**
Phone: _____
Birth Date: _____ Sex: _____ _____ **Program: _____**
(mm/dd/yy) M F

Contact Phone Numbers: _____ (W) _____ (H)

Emergency Contacts: _____

GENERAL MEDICAL SCREENING (explain any positive responses on Continuation Page)

	Yes	No		Yes	No
Cancer (not in remission)	___	___	**Tuberculosis**	___	___
Asthma	___	___	**Paralysis**	___	___
Epilepsy	___	___	**Impaired Mobility**	___	___
Heart Attack	___	___	**Severe Hearing Loss**	___	___
Diabetes	___	___	**Chest Pain**	___	___
Anemia (current)	___	___	**Claustrophobia**	___	___
Lung Disease	___	___	**Panic Attacks**	___	___
Otitis Media (current)	___	___	**Dizziness/Vertigo**	___	___
Pacemaker	___	___	**Loss of Consciousness**	___	___
Severe Loss of Vision	___	___	**Severe Motion Sickness**	___	___
Sinusitis (current)	___	___	**Recent Significant Trauma**	___	___

*****If you have been scuba diving within 24 hours of flying, have had any dental procedures within 48 hours of flying, or you are pregnant – YOU MUST CONSULT WITH A FLIGHT SURGEON.**

List Current Medications: _____ _____
_____ _____
_____ _____

Are you aware of any other medical condition(s) that may affect your suitability for aviation duty? No Yes
If yes, please explain on the continuation page

If you have any questions, please contact the appropriate Health Services Office:

Aircraft Operations Center: 813-828-3310 x-3102 (Office) / 813-294-6703 (Cellular)
Marine Operations Atlantic: 757-441-6320 (Office) / 757-615-6619 (Cellular)
Marine Operations Pacific: 206-553-8704 (Office) / 206-409-8725 (Cellular)
Director, NMAO Health Services: 301-523-7792 x-186 (Office) / 301-523-7792 (Cellular)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment. **ANY CHANGES IN YOUR MEDICAL CONDITION SINCE YOU LAST COMPLETED THIS MEDICAL HISTORY FORM, MUST BE REPORTED TO THE NOAA FLIGHT SURGEON IMMEDIATELY.**

_____ _____
Employee Signature Date (mm/dd/yy)

----------[Below section to be completed by NOAA Medical Officer]----------

MEDICALLY CLEARED FOR AVIATION DUTY BY HISTORY: YES NO NEED MORE INFO

_____ _____
AOC / MOA / MOP Regional Director of Health Services Date (mm/dd/yy)

DRAFT

Name: _____

NOAA Health Services Aviation Questionnaire Continuation Page

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